| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (| | (X2) MULTIPLE CONSTRUCTION (X3) | | | (X3) DATE | SURVEY | |
|--|----------------------|---------------------------------|----------------------|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 01 COMPL | | ETED | | |
| | | 155775 | A. BUIL B. WINC | | | 05/16/2 | 011 |
| | | | D. WINC | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | UMBERLAND AVE | | |
| CLIMBER | RLAND POINTE HE | ALTH CAMPLIS | | | LAFAYETTE, IN47906 | | |
| | | | | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | l . | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENC!) | | DATE |
| K0000 | | | | | | | |
| | | | 17.0 | 000 | Currey Event ID: | | |
| | | ode Recertification | K0 | 000 | Survey Event ID: ZC0621 The subm | ieeion | |
| | and State Licer | isure Survey was | | | of this POC does not indicate | | |
| | conducted by t | the Indiana State | | | admission by Cumberland | | |
| | Department of | Health in | | | Pointe Health Campus that t | | |
| | - | th 42 CFR 483.70(a). | | | findings and allegations conf | | |
| | | - \ | | | herein are accurate and true | | |
| | Survey Date: 0 | 05/16/11 | | | representations of the quality | | |
| | Survey Date. C | 73/10/11 | | | care and services provided t residents of Cumberland Po | | |
| | - 11: 11 | 000545 | | | Health Campus. This facility | iiito | |
| | Facility Numbe | | | | recognized it's obligation to | | |
| | Provider Numb | er: 155775 | | | provide legally and medically | / | |
| | AIM Number: | 100267440 | | | necessary care and services | | |
| | | | | | residents in an economic an | | |
| | Surveyor: Brid | get Brown, Life | | | efficient manner. The facility | | |
| | Safety Code Sp | | | | hereby maintains it is in | tha | |
| | Surety Code Sp | ecianse | | | substantial compliance with requirements of participation | | |
| | A++ a:a :faCaf | atri Cada augusi | | | comprehensive health care | 101 | |
| | | ety Code survey, | | | facilities (for Title 18/19 | | |
| | | ointe Health Campus | | | programs).To this end, this p | lan | |
| | | in compliance with | | | of correction shall serve as t | | |
| | Requirements | for Participation in | | | credible allegation of complia | ance | |
| | Medicaid, 42 C | FR Subpart | | | with all state and federal requirements governing the | | |
| | 483.70(a), Life | Safety from Fire | | | management of this facility. | lt is | |
| | and the 2000 (| edition of the | | | thus submitted as a matter of | | |
| | National Fire P | rotection | | | statute only. | | |
| | | FPA) 101, Life Safety | | | | | |
| | , | apter 19, Existing | | | | | |
| | | · · | | | | | |
| | | ccupancies and 410 | | | | | |
| | IAC 16.2. | | | | | | |
| | | | | | | | |
| | This facility wa | is located on the | | | | | |
| | east wing of a | one story fully | | | | | |
| | sprinklered bu | ilding determined to | | | | | |
| | - | | 1 | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZCO621

Facility ID:

000547

TITLE

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|--|--|---|---|---------|---|-----------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING O1 COMPLETED | | | | |
| | | 155775 | B. WIN | G | | 05/16/20 | 011 |
| | PROVIDER OR SUPPLIER | | | 1051 Cl | DDRESS, CITY, STATE, ZIP CODE JMBERLAND AVE LAFAYETTE, IN47906 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | DECLIFERED IN A LANCE CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | re | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | ļ | TAG | DEFICIENCY) | | DATE |
| | The facility has with smoke det corridors and s corridors. The capacity for 14 of 117 at the ti | paces open to the facility has the 3 and had a census me of this survey. If found not in h the | | | | | |
| K0011 SS=E | nonconforming but fire barrier having resistance rating or required for the accopenings occur or protected by approful. 1.4.1, 19.1.1. Based on observinterview, the fensure 1 of 1 departier separation from the assist provided the purious for a two hour 19.1.1.4.2 references | vation and acility failed to loors in the fire | KO | 011 | CORRECTIVE ACTIONThis door separating health care f assisted living occupancy wa installed as part of the addition the assisted living in 1997 and pass LSC inspection and me LSC code requirements. A quis being obtained for purchas and installation of fire doors with a one and one-half hour designated rating in the two lifter barrier. Due to the length | rom as on of ad did et uote se of | 08/01/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZCO621 Facility ID:

000547

If continuation sheet

Page 2 of 24

| | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | | |
|-----------|----------------------|------------------------------|--------|---------------------|--|-------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 01 | COMPL | | |
| | | 155775 | B. WIN | IG | | 05/16/2 | 011 | |
| NAME OF 1 | PROVIDER OR SUPPLIER | : } | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | | |
| OLIMPE | OLAND DOINTE LIE | ALTIL CAMPUO | | 1051 CUMBERLAND AVE | | | | |
| | RLAND POINTE HE | | | WEST | _AFAYETTE, IN47906 | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΤE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | time for delivery of the fire do | oore | DATE | |
| | | rier be provided | | | from the manufacturer that is | | | |
| | | ing at least a 1 1/2 | | | anticipated to be 6-8 weeks, | | | |
| | · · | ction rating. This | | | campus is requesting | | | |
| | deficient practi | ice could affect | | | an extension of 60 days for t | | | |
| | visitors, staff a | nd 44 residents of | | | completion date. Staff will be educated during the 60 day | ; | | |
| | the compreher | isive care unit. | | | period that the two hour fire | | | |
| | | | | | barrier will only provide one | hour | | |
| | Findings includ | le: | | | of protection and residents w | | | |
| | | | | | moved to another compartme | | | |
| | Based on obse | rvation with the | | | with approved fire doors in the two hour fire barrier during a | | | |
| | maintenance d | irector on 05/16/11 | | | alarm where compartment | IIIC | | |
| | | the door installed | | | evacuation would be needed | l. | | |
| | · · | ire separation wall | | | IDENTIFY OTHER | | | |
| | | ealth care center | | | RESIDENTSAll residents | | | |
| | | ving quarters had a | | | affected were identified in the finding. No other residents w | | | |
| | | | | | be impacted. | ould | | |
| | | ating, less than the | | | MEASURES/SYSTEMIC | | | |
| | one and one ha | | | | CHANGESThe Plant Operat | ions | | |
| | | door in a two hour | | | Director will be in-serviced | | | |
| | fire wall. The i | | | | regarding the fire rating requirements for doors in a t | wo | | |
| | director said at | | | | hour fire separation wall. All | | | |
| | • | e was unaware of | | | in two hour fire separation w | | | |
| | fire rating requ | iirements. | | | the campus have been inspe | | | |
| | | | | | to ensure the fire ratings on t | | | |
| | 3.1-19(b) | | | | doors are in compliance with doors being rated with a one | | | |
| | | | | | one-half hour rating. A month | | | |
| | | | | | preventative maintenance ch | neck | | |
| | | | | | will be conducted to ensure t | hat | | |
| | | | | | all doors in the two hour fire separation walls continue to | have | | |
| | | | | | the proper rating noted on th | | | |
| | | | | | doors. MONITORING | - | | |
| | | | | | CORRECTIVE ACTIONThe | | | |
| | | | | | monthly preventative | | | |
| | | | | | maintenance check audit res | sults | | |
| | | | | | will be reported to the QA | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155775 | | | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 05/16/2011 |
|---|---|--|--|--|--|
| | ROVIDER OR SUPPLIER | | STREET A | UDDRESS, CITY, STATE, ZIP CODE JMBERLAND AVE LAFAYETTE, IN47906 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| K0021 SS=E | enclosure, horizon hazardous area er | t passageway, stairway tal exit, smoke barrier or nclosure is held open only | | committee for three months. any negative trends are note the audit results, the QA committee will recommend changes in the interventions extend the monthly review all additional three months to er effectiveness of the new interventions. | and n |
| | such doors by zon upon activation of: a) the required ma | ed to automatically close all e or throughout the facility nual fire alarm system; ectors designed to detect | | | |
| | smoke passing thr required smoke de | ough the opening or a stection system; and orinkler system, if installed. | | | |
| | hazardous area only with a dev the door to clos This deficient p | doors to 4 of 12 as were held open ace which allowed as automatically. aractice could affect and 77 residents on e: | K0021 | the medical supply storage in near 208 and 308, to room 3 and the activities storage room near 316 are being rep to ensure the doors self-closure device on the double doors to the kitchen is being replaced to ensure the doors self-close and latch. A quote is been obtained for purchase of and installation onew self-closure device. Due the length of time for delivery installation of the self-closure device that is anticipated to | ooms 30 paired e. 2. ne s e to y and e to |
| | | rector on 05/16/11 | | be 4-6 weeks, the campus is requesting an extension of 4 | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | INSTRUCTION 01 | (X3) DATE S COMPL | |
|----------|----------------------------------|---|--------|------------|--|----------------------|------------|
| THEFTERN | or connection | 155775 | | LDING | | 05/16/2 | |
| | | 1.557.75 | B. WIN | | ADDRESS CITY STATE TIN CODE | 00/10/2 | |
| NAME OF | PROVIDER OR SUPPLIEI | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE UMBERLAND AVE | | |
| CUMBE | RLAND POINTE HE | EALTH CAMPUS | | 1 | LAFAYETTE, IN47906 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | between 10:15 | a.m. and 2:20 | | | days for the completion | | |
| | p.m., self closi | ng doors in the | | | date. Staff will be educated | tho | |
| | following areas | failed to self close: | | | during the 45 day period that double kitchen doors to the | uie | |
| | 1 | ical supply storage | | | service corridor may not late | h | |
| | | 8 and 308 when | | | properly and kitchen staff wil | | |
| | they | | | | required to close and latch th | | |
| | hit the door | r frame | | | kitchen doors as they exit the kitchen in a fire alarm. IDEN | | |
| | | 80 when the door hit | | | OTHER RESIDENTSAll resi | | |
| | | | | | affected were identified in the | | |
| | the unlevel car | | | | finding. No other residents w | ould | |
| | | ities storage room | | | be impacted. | | |
| | | n the door hit the | | | MEASURES/SYSTEMIC | : | |
| | door frame | | | | CHANGESThe Plant Operat Director will be in-serviced | ions | |
| | The maintenar | ice director said at | | | regarding the requirements f | or | |
| | the time of the | observations, the | | | self-closing devices and prop | | |
| | doors would re | equire repair. | | | function of the self-closing | | |
| | | | | | devices on doors to hazardo | | |
| | 3.1-19(b) | | | | areas. A monthly preventativ maintenance inspection will l | | |
| | | | | | conducted on all doors to | Je | |
| | 3 8 | hara arta a a d | | | hazardous areas to ensure t | he | |
| | 2. Based on ol | | | | self-closing devices on those | | |
| | | facility failed to | | | doors allow the doors to clos | | |
| | ensure 1 of 12 | | | | automatically upon activation the fire alarm system and lat | | |
| | | a would self close. | | | properly. MONITORING | OI I | |
| | Sprinklered ha | zardous areas are | | | CORRECTIVE ACTIONThe | | |
| | required to be | equipped with self | | | monthly preventative | | |
| | closing doors | or with doors that | | | maintenance check audit res | sults | |
| | close automati | cally upon | | | will be reported to the QA committee for three months. | lf | |
| | activation of th | ne fire alarm system. | | | any negative trends are note | | |
| | | loors to hazardous | | | the audit results, the QA | | |
| | | ired to latch in the | | | committee will recommend | | |
| | | en closed to keep | | | changes in the interventions | | |
| | the door tightly closed. This | | | | extend the monthly review an additional three months to er | | |
| | _ | ice affects 4 staff in | | | effectiveness of the new | isuie | |
| | deficient pract | ice affects + staff iii | | | interventions. | | |
| | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| NAME OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS INTELL TAPORTES, CITY, STATE, JOP COURT TAG REPRESENTATION OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS IDSTITUTION OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS WEST LAFAYETTE, IN47906 (A3) REPRESENTATION OR SUPPLIER (LACH IDERCINCY MIST BE PERCEIVED BY PILL) TAG REPRESENTATION OR BECHAPTEVING INFORMATIONS) the kitchen. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) K0025 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an attum wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure openings through ceiling generator transfer switch room | STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|-----------|------------------------|---------------------------------------|----------------|-------------------------------|-------------------------------------|----------|------------------|--|
| NAME OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS (EACH DEFICIENCY AUST 85 PERCEDED BY FULL RIGHT AND YOUR INCIDINTIFYING INFORMATION) THE kitchen. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) K0025 Smoke barriers are constructed to provide at least a one half hour fife resistance rating in accordance with 8.3. Smoke barriers may terminate at an attimum wall. Windows are protected by fire-rated glazing or by wired glass panels and stele frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 01 | | | COMPLI | ETED | |
| NAME OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS INCOMPRESS AND POINTE HEALTH CAMPUS INCOMPRESS (IT) STATE LIP FOOD INCOMPRESS (IT) STATE I | | | 155775 | 1 | | | 05/16/20 | 011 | |
| CUMBERLAND POINTE HEALTH CAMPUS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY PULL TAG REGOLATORY OR LSC DENTIFYING INFORMATION) the kitchen. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1-19(b) K0025 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 3.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to the service of the service o | NAME OF B | DROVIDED OD CLIDDI IED | | - | STREET A | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | | |
| NA-JID SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PERCEDED BY FULL TAG TA | NAME OF P | KOVIDER OR SUPPLIER | | | 1051 C | UMBERLAND AVE | | | |
| ### REGULATORY OR LSC IDENTIFYING INFORMATION the kitchen. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) **RO02.5** SS=E** Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, semilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | CUMBER | RLAND POINTE HE | ALTH CAMPUS | | WEST | LAFAYETTE, IN47906 | | | |
| the kitchen. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) K0025 SS=E Smoke barriers are constructed to provide at least a one half hour fife resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | | | | | PROVIDER'S PLAN OF CORRECTION | | | | |
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| Findings include: Based on observation with the maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) K0025 SS=E Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, vertiliating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | IAG | | LSC IDENTIFY ING INFORMATION) | + | IAG | DEFICIENCE) | | DATE | |
| Based on observation with the maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | | the kitchen. | | | | | | | |
| maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | | Findings includ | le: | | | | | | |
| at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | | Based on obser | vation with the | | | | | | |
| doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | | maintenance di | irector on 05/16/11 | | | | | | |
| service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1–19(b) Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to | | at 1:10 p.m., se | elf closing double | | | | | | |
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| Based on observation and interview, the facility failed to K0025 CORRECTIVE ACTIONa. The foam in the eight conduit penetrations in the boiler and | | | | | | | | | |
| interview, the facility failed to foam in the eight conduit penetrations in the boiler and | | | · · · · · · · · · · · · · · · · · · · | | | | | | |
| penetrations in the boiler and | | Based on obser | vation and | K(| 0025 | | ne | 06/15/2011 | |
| | | interview, the f | acility failed to | | | _ | , | | |
| | | ensure opening | gs through ceiling | | | | | | |
| | | | | | | | | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155775 05/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1051 CUMBERLAND AVE **CUMBERLAND POINTE HEALTH CAMPUS** WEST LAFAYETTE, IN47906 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE ceiling and wall openings is being and wall smoke barriers in 3 of 6 removed and the penetration smoke compartments were filled with a fire rated caulk. b. protected with approved materials The foam in the opening of the to maintain the smoke resistance sprinkler pipe in the ceiling in the freezer is being removed and the of the smoke barrier. LSC Section penetration filled with a fire rated 8.3.6.1 requires the passage of caulk. c The opening in the building service materials such as ceiling around a waterline pipe, cable or wire to be protected penetration in the kitchen adjacent to the range hood is so that the space between the being sealed with a fire rated penetrating item and the smoke caulk. IDENTIFY OTHER barrier shall be filled with a RESIDENTSAll residents affected were identified in the finding. No material capable of maintaining other residents would be the smoke resistance of the smoke impacted. barrier or be protected by an MEASURES/SYSTEMIC approved device designed for the **CHANGESThe Plant Operations** Director will be in-serviced specific purpose. This deficient regarding the requirements for could affect visitors, staff and 20 properly protecting ceiling and or more residents in Wing 2, 3, 6, wall penetrations with an approved material capable of 9 and the main lounge. maintaining the smoke resistance of the smoke barrier. All Plant Findings include: Operations staff will be in-serviced regarding the need to ensure any new penetrations in a Based on observation with the smoke barrier must be filled with maintenance director on 05/16/11 a fire rated caulk. An audit form is between 10:15 a.m. and 2:20 being created to document the p.m., the following was observed: monthly inspection of smoke barriers to ensure no open a. Openings around eight conduit penetrations are observed and penetrations in the boiler and that all penetrations are filled with generator transfer switch room a fire rated caulk. MONITORING **CORRECTIVE ACTIONThe** ceiling and wall were filled with monthly audit results will be expandable foam; reported to the QA committee for b. The opening around the three months. If any negative sprinkler pipe in the ceiling in the trends are noted in the audit

000547

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE S | | | |
|---|--------------------------------------|--|------------|---|---|------------------|--------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155775 | A. BUIL | DING | 01 | COMPL 05/16/2 | | |
| | | 199779 | B. WING | | | 03/10/20 | 011 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | | |
| CUMBER | RLAND POINTE HE | ALTH CAMPUS | | | JMBERLAND AVE .AFAYETTE, IN47906 | | | |
| | | | | | | | (115) | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | DATE | |
| | freezer | | | | results, the QA committee wi | II | | |
| | was filled with an expandable | | | | recommend changes in the | y I | | |
| foam; | | | | interventions and extend the monthly review an additional | | | | |
| | | g in the ceiling | | | three months to ensure | | | |
| | · | line penetration in | | | effectiveness of the new | | | |
| | the | | | | interventions. | | | |
| | | acent to the range | | | | | | |
| | _ | aled leaving a 1/2 | | | | | | |
| | inch annula | _ | | | | | | |
| | | ce director said at | | | | | | |
| the time of observations, he was | | | | | | | | |
| | unaware of requirements for | | | | | | | |
| | protecting ceili | ng and wall | | | | | | |
| | penetrations. | | | | | | | |
| | • | | | | | | | |
| | 3.1-19(b) | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| K0029 | One hour fire rate | d construction (with ¾ hour | | | | | | |
| SS=E | | r an approved automatic fire | | | | | | |
| - | | em in accordance with 8.4.1 | | | | | | |
| | and/or 19.3.5.4 pro When the approve | otects hazardous areas. | | | | | | |
| | | em option is used, the areas | | | | | | |
| | | n other spaces by smoke | | | | | | |
| | | and doors. Doors are | | | | | | |
| | | on-rated or field-applied hat do not exceed 48 inches | | | | | | |
| | | f the door are permitted. | | | | | | |
| | 19.3.2.1 | | | | | | | |
| | Based on obser | vation and | K0 | 029 | CORRECTIVE ACTIONAuto | | 07/15/2011 | |
| | interview, the f | acility failed to | | | self-closing devices are being added to the medical | 9 | | |
| | provide automa | atic closing devices | | | records/supply storage room | near | | |
| | on hazardous r | oom doors in 2 of | | | 308 and to the comprehensive | | | |
| | 8 smoke compa | artments. This | | | shower room used for collect | ion | | |
| | | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZCO621 Facility ID:

000547

If continuation sheet

Page 8 of 24

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155775 | | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 05/16/2011 | |
|---|--|---|---------------------|--|--|
| | PROVIDER OR SUPPLIER | | 1051 C | ADDRESS, CITY, STATE, ZIP CODE UMBERLAND AVE LAFAYETTE, IN47906 | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 5.112 |
| | staff and 77 reunit. Findings included Based on observation, he with self closing devices director said at observation, he with self closing he comprehence the comprehence t | rvations on veen 10:15 a.m. and medical records/room near 308 and sive shower room earts each had ere not equipped. | | of soiled linen and trash car quote is been obtained for purchase of and installation of these new self-closure devices. Due to the length of for delivery and installation self-closure devices that is anticipated to be 4-6 weeks campus is requesting an extension of 45 days for completion date. Staff will be ducated during the 45 day period that the doors to the medical records/supply stor room near 308 and the comprehensive shower room used for collection of soiled and trash carts will not close automatically and staff will be required to close and latch the doors if open when a fire alsonds. IDENTIFY OTHER RESIDENTSAll residents as were identified in the finding other residents would be impacted. MEASURES/SYS C CHANGESThe Plant Operations Director will be in-serviced regarding the requirements for self-closing devices and proper function self-closing devices on door hazardous areas. A monthly preventative maintenance inspection will be conducted doors to hazardous areas to ensure the self-closing devictions devices automatically upon activation of the fire alarm so and latch properly. MONITO CORRECTIVE ACTIONThe | of time of the the the the e age m linen e be the arm fected g. No TEMI TEMI Temporary of the est to your control of the est to |

Facility ID:

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155775 | | | (X2) MU A. BUII B. WIN | LDING | 01 | (X3) DATE S COMPL 05/16/2 | ETED |
|--|---|---|------------------------------|---------------------|--|---|----------------------------|
| | PROVIDER OR SUPPLIER | | | 1051 CU | DDRESS, CITY, STATE, ZIP CODE IMBERLAND AVE AFAYETTE, IN47906 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| K0048 SS=E | There is a written patients and for the of an emergency. Based on observeiew and interfailed to develor and train staff of plan for staff resord smoke de 40 of 117 residents. Findings include Based on obsermaintenance di 10:15 a.m. and 05/16/11, indi detectors were rooms 101 to 1 review of the far Procedures with | plan for the protection of all eir evacuation in the event 19.7.1.1 evation, record rview; the facility op a written plan to implement the esponse to resident etectors to protect lents. This ce could affect 40 e: e: evations with the erector between 11:00 a.m. on vidual smoke located in resident 20. Based on | KO | 0048 | monthly preventative maintenance check audit res will be reported to the QA committee for three months. any negative trends are note the audit results, the QA committee will recommend changes in the interventions extend the monthly review ar additional three months to er effectiveness of the new interventions. CORRECTIVE ACTIONFire procedures for the campus d require staff to activate the nearest pull station if they observe smoke or fire and th alarm is not sounding. The p- is being revised to clearly sta- that if a staff member hears a battery powered smoke dete- sounding they are to immedia respond to the room and if sr or fire is observed to remove resident(s) and activate the nearest pull station. If smoke fire is not observed the staff a to immediately contact Plant Operations to inspect the sm detector. IDENTIFY OTHER RESIDENTSAll residents affi were identified in the finding. other residents would be impacted. MEASURES/S EMIC CHANGESStaff member from all departments will be in-serviced on the revised fire procedures. An audit will be conducted monthly of all batt | o e fire olicy ate a ctor ately moke the orare oke ected No | 06/15/2011 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155775 | | (X2) MUI A. BUILE B. WING | DING | 01 | (X3) DATE S COMPL 05/16/20 | ETED | |
|--|--|--|------|--------------------|---|--|----------------------------|
| | PROVIDER OR SUPPLIER | | • | 1051 CU | ODRESS, CITY, STATE, ZIP CODE MBERLAND AVE AFAYETTE, IN47906 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | P | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Έ | (X5) COMPLETION DATE |
| | specific respon powered smoke The maintenan- the time of reco of no policy for | e detector alarm. ce director said at ord review, he knew a special response battery powered | | | powered smoke detectors to ensure the units are functioning properly. MONITORING CORRECTIVE ACTIONThe aresults of the monthly checks battery powered smoke detectors will be reported to to QA committee for three montany negative trends are noted the audit results, the QA committee will recommend changes in the interventions extend the monthly review are additional three months to eneffectiveness of the new interventions. | audit s of the hs. If d in | |
| K0056 SS=E | installed in accord Standard for the Ir Systems, to provide portions of the build properly maintaine 25, Standard for the Maintenance of W Systems. It is fully reliable, adequate system. Required equipped with wat switches, which are the building fire also 1. Based on obtain interview, the forevide sprinkly 1 exterior emerged. | servation and acility failed to er coverage for 1 of | K00 | 056 | CORRECTIVE ACTION1. Th sunshade lattice canopy outs the Comprehensive dining ro is not attached to the building is leaning towards the building and bracing will be installed of the lattice to restore the lattic it's proper vertical position. 2. | side om g. It g on e to | 06/15/2011 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | URVEY |
|--|-----------------------|--|---------|--------------|--|-------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDING | 01 | COMPLE | ETED |
| | | 155775 | B. WIN | | | 05/16/20 | 011 |
| | | | D. 1111 | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | 1 | UMBERLAND AVE | | |
| CUMBER | RLAND POINTE HE | ALTH CAMPUS | | 1 | LAFAYETTE, IN47906 | | |
| | | | | | | | 075) |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ſΕ | DATE |
| IAG | | · | + | IAG | Upon follow-up inspection the | ore | DAIL |
| | 13, 1999 Editio | | | | are not three pendant ceiling | | |
| | · · | lers be installed | | | sprinkler heads spaced five f | | |
| | under combust | tible exterior roofs | | | apart in the Pines assisted d | ~ 1 | |
| | or canopies ex | ceeding four feet in | | | room. All sprinkler heads in t | | |
| | width. This de | ficient practice | | | Pines assisted dining room a | re | |
| | affects residen | ts, staff, and at at | | | spaced properly. IDENTIFY OTHER RESIDENTSAll residents | dents | |
| | least 20 reside | nts using the | | | affected were identified in the | | |
| | comprehensive | care dining room. | | | finding. No other residents w | ould | |
| | ' | 3 | | | be impacted. | | |
| | Findings includ | le: | | | MEASURES/SYSTEMIC | | |
| | Tillalligs literae | | | | CHANGESThe sunshade lat canopy will be inspected more | | |
| | Pacad on obco | rvation with the | | | during grounds inspection to | | |
| | | | | | ensure it is remaining braced | | |
| | | irector on 05/16/11 | | | properly away from the build | ing. | |
| | · · | a twelve by eight | | | MONITORING CORRECTIV | | |
| | foot wooden la | | | | ACTIONThe grounds inspec | | |
| | canopy was att | ached to the | | | reports will be submitted to the QA committee for three mon | | |
| | building outsid | le the | | | ensure the bracing is properl | | |
| | comprehensive | care dining room. | | | keeping the lattice canopy fro | - 1 | |
| | The covered ar | ea included the | | | contact with the building. Sho | | |
| | emergency exi | t from the dining | | | any negative trends be noted | | |
| | | intenance director | | | additional bracing or adjustm to the lattice canopy will be | ent | |
| | | ime of observation, | | | implemented and the ground | ls | |
| | _ | n material was | | | inspection reports will be | - | |
| | | The area was not | | | monitored for an additional th | rree | |
| | | | | | months to ensure compliance | e. | |
| | protected by s | officiers. | | | | | |
| | | | | | | | |
| | 3.1-19(b) | | | | | | |
| | 2. Based on ol | servation and | | | | | |
| | | | | | | | |
| | interview, the f | - | | | | | |
| | | inimum distance | | | | | |
| | between sprink | | | | | | |
| | resident use ar | eas. NFPA 13, | | | | | |
| | i | | 1 | | İ | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURVEY COMPLETED 05/16/2011 | | | |
|---|----------------------|---|---------------|--|--------------------|
| | | 100770 | B. WING | ET ADDRESS, CITY, STATE, ZIP CODE | 03/10/2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | I | I CUMBERLAND AVE | |
| CUMBEF | RLAND POINTE HE | ALTH CAMPUS | | ST LAFAYETTE, IN47906 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| | | : 4–7.3.4 requires | | | |
| | | be spaced not less | | | |
| | than 6 feet on | · · · · · · · · · · · · · · · · · · · | | | |
| | | ce affects staff, | | | |
| | • | residents on the | | | |
| | Pine unit. | | | | |
| | Findings includ | e: | | | |
| | Based on obser | | | | |
| | | irector on 05/16/11 | | | |
| | • | rree pendant ceiling | | | |
| | | were spaced five | | | |
| | | nother in the Pines | | | |
| | | ning room. The irector agreed at | | | |
| | the time of obs | | | | |
| | | s were not at the | | | |
| | minimum dista | | | | |
| | apart. | nee or six reet | | | |
| | • | | | | |
| | 3.1-19(b) | | | | |
| | | | | | |
| K0062 | | ic sprinkler systems are | | | |
| SS=E | | tained in reliable operating | | | |
| | | inspected and tested 7.6, 4.6.12, NFPA 13, NFPA | | | |
| | 1. Based on ob | servation and | K0062 | CORRECTIVE ACTION1. S | pare 06/15/2011 |
| | interview, the f | acility failed to | | sprinkler heads have been ordered to be on hand to en | sure |
| | ensure a supply | y of spare sprinkler | | the minimum replacement he | |
| heads included at least two of | | at least two of | | are available in the building | for |
| | each type of sp | rinkler head | | each type of sprinkler head. | 2. |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | |
|--|----------------------|------------------------------|--------|-------------------------|--|---------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | A. BUILDING 01 | | | COMPLETED | |
| | | 155775 | B. WIN | | | 05/16/2 | 011 | |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF | PROVIDER OR SUPPLIEF | ₹ | | 1051 C | UMBERLAND AVE | | | |
| | RLAND POINTE HE | ALTH CAMPUS | | WEST LAFAYETTE, IN47906 | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | | | DATE | |
| | | facility for 1 of 1 | | | The installation of the sprinkl heads in the comprehensive | | | |
| | automatic spri | nkler systems. | | | unit medicine storage room a | | | |
| | NFPA 25, 2-4. | 1.4 requires a | | | the medical records/storage | | | |
| | supply of at lea | ast six spare | | | near 308 have been correcte | d so | | |
| | sprinklers shal | l be stored in a | | | sprinkler heads are properly | | | |
| | cabinet on the | premises for | | | installed. A new sprinkler hea | | | |
| | | urposes. The stock | | | was ordered and will be insta for the Pines utility room. 3. | | | |
| | of spare sprink | • | | | new sprinkler head has beer | | | |
| | | representative of | | | ordered for the Kitchen | | | |
| | 1 | emperature ratings | | | freezer and will be installed a | | | |
| | 1 | • | | | soon as delivered. IDENTIF | | | |
| | of the system s | = | | | OTHER RESIDENTSAII spriin heads in the entire building h | | | |
| | | o sprinklers of each | | | been inspected and no other | | | |
| | type and temp | | | | sprinkler heads were found v | | | |
| | installed shall | be provided. This | | | improper installation. No othe | | | |
| | deficient practi | ice could affect 77 | | | residents would be affected. | | | |
| | residents in the | e Pines unit. | | | MEASURES/SYSTEMIC | | | |
| | | | | | CHANGESA monthly audit o spare sprinkler heads will be | | | |
| | Findings includ | le: | | | completed to ensure at least | | | |
| | | | | | of each type of sprinkler | | | |
| | Rased on obse | rvation with the | | | are stored in a cabinet on the | • | | |
| | | irector on 05/16/11 | | | premises for replacement | | | |
| | | | | | purposes. Each | Lilaa | | |
| | at 1:55 p.m., s | | | | quarter inspection of all sprin heads will be completed to | ikier | | |
| | | ated in the boiler | | | ensure they are clean, prope | rlv | | |
| | · | oply did not include | | | installed, and in reliable oper | - | | |
| | | ase sprinkler head | | | condition.MONITORING | - | | |
| | which were ob | served in the | | | CORRECTIVE ACTIONThe | | | |
| | resident rooms | and common areas | | | monthly audit of spare | | | |
| | on the Pines ur | nit. The | | | sprinklers and the quarterly inspection of sprinkler heads | will | | |
| | maintenance d | irector said at the | | | be reported to the QA comm | | | |
| | time of observa | ation, he did not | | | for three months. If any nega | | | |
| | | spare sprinkler | | | trends are noted in the audit | | | |
| | • | ld not say at the | | | results, the QA committee wi | II | | |
| | | ery, if the heads on | | | recommend changes in the | | | |
| | Little of discove | ery, ir tile fleaus off | | | interventions and extend the | | | |

000547

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CC | | (X3) DATE SURVEY COMPLETED | |
|--|--------------------------------|------------------------------|-------------|---|------------|
| ANDILAN | OF CORRECTION | 155775 | A. BUILDING | 01 | 05/16/2011 |
| | | 133770 | B. WING | ADDRESS, CITY, STATE, ZIP CODE | 00/10/2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | UMBERLAND AVE | |
| CUMBER | RLAND POINTE HE | ALTH CAMPUS | l l | LAFAYETTE, IN47906 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | |
| PREFIX | • | CY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | PRIATE |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | monthly review an additio | DATE |
| | <u>-</u> | red all other types | | three months to ensure | liai |
| | of sprinklers in | stalled in the | | effectiveness of the new | |
| | facility. | | | interventions. | |
| | 3.1-19(b) | | | | |
| | | | | | |
| | 2. Based on ob | | | | |
| | · · | ensure sprinkler | | | |
| | = | g protection for 2 | | | |
| | maintained. Th | npartments were | | | |
| | | | | | |
| | visitors and re | affect any staff, | | | |
| | | | | | |
| | vicinity of the t involved. | mree rooms | | | |
| | invoivea. | | | | |
| | Findings includ | le: | | | |
| | Based on obser | rvations during a | | | |
| | tour of the faci | | | | |
| | | irector on 05/16/11 | | | |
| | between 10:15 | | | | |
| | | head escutcheons | | | |
| | were missing, i | | | | |
| | _ | splaced, leaving a | | | |
| | · · | 1/2 inch into the | | | |
| | | he soiled utility | | | |
| | room on the Pi | | | | |
| | medicine room | | | | |
| | comprehensive | unit and the | | | |
| | • | s/storage room | | | |
| | near 308. | . . | | | |
| | | | | | |
| | | | | | |

000547

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155775 | | (X2) MULTIPLE A. BUILDING B. WING | O1 | COMPI | (X3) DATE SURVEY COMPLETED 05/16/2011 | |
|--|--|---|---------------------|---|---|----------------------------|
| | PROVIDER OR SUPPLIER | | STREE 1051 | ET ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND AVE T LAFAYETTE, IN47906 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | service areas w materials, such 25, 2-2.1.1 red be free of forei corrosion. This affects 4 kitched Findings includ Based on obser maintenance di at 1:05 p.m., the sprinkler head thick grey grim maintenance di the time of observations | acility failed to er heads in 1 of 6 as free of foreign as grime. NFPA quires sprinklers to gn materials and s deficient practice en staff. de: evation with the frector on 05/16/11 ne kitchen freezer was covered with a e. The frector agreed at fervation, the was not in good | | | | |
| K0069 SS=D | | | K0069 | CORRECTIVE ACTIONT kitchen floor will be marke identify the proper placen | ed to | 06/15/2011 |

| | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | | |
|-------------------|---------------------|---|--|--|--|----------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155775 | A. BUI | LDING | 01 | COMPLETED 05/16/2011 | |
| | | 199779 | B. WIN | _ | | 05/10/2011 | |
| NAME OF F | ROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| CLIMBEE | RLAND POINTE HE | ALTH CAMPLIS | | 1051 CUMBERLAND AVE WEST LAFAYETTE, IN47906 | | | |
| | | | | | _AFATETTE, IN47900 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | TE COMPLETION DATE | |
| 1710 | | · · · · · · · · · · · · · · · · · · · | + | 1110 | the fryer to ensure it is fully | DATE | |
| | | ommercial cooking | | | covered by the hood protecti | on | |
| | extinguishing s | | | | system. IDENTIFY OTHER | | |
| | maintained. NI | | | | RESIDENTSAll residents aff | | |
| | requires autom | | | | were identified in the finding. other residents would be | INO | |
| | extinguishing s | | | | impacted. | | |
| | | andard UL 300, Fire | | | MEASURES/SYSTEMIC | | |
| | Testing of Fire | | | | CHANGESThe Plant Operat | ions | |
| | Systems for Pro | | | | Director will be in-serviced regarding the hood protection | n | |
| | | king Areas. This | | | requirements for the | " | |
| | deficient practi | ce could affect 4 | | | kitchen.Dining services cook | ing | |
| | kitchen staff. | | | | staff will be in-serviced regar | | |
| | Findings includ | e: | the importance of ensuring the fryer is properly positioned under the hood at all times. An audit to be completed weekly to ensure | | | nder dit will | |
| | Based on obser | vation of the | | | kitchen cooking equipment is | | |
| | commercial kite | chen range hood | | | properly positioned under the | e | |
| | protection syst | _ | | | hood protection system. MONITORING CORRECTIV | _ | |
| | - | rector on 05/16/11 | | | ACTIONThe weekly audit res | I | |
| | | rotection was not | | | will be reported to the QA | | |
| | | ght inches of the | | | committee for three months. | | |
| | · · | not positioned | | | any negative trends are note | d in | |
| | • | I. The maintenance | | | the audit results, the QA committee will recommend | | |
| | director said at | | | | changes in the interventions | and | |
| | observation, he | | | | extend the monthly review a | I | |
| | anything about | | | | additional three months to er | nsure | |
| | protection requ | | | | effectiveness of the new interventions. | | |
| | protection requ | mements. | | | into vontions. | | |
| | 3.1-19(b) | | | | | | |
| | J.1-13(U) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155775 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING B. WING | | ETED | | | |
|---|---|---|---|---------------------|---|------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1 | 1051 CL | DDRESS, CITY, STATE, ZIP CODE JMBERLAND AVE AFAYETTE, IN47906 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| K0076 SS=E | are protected in ac Standards for Head (a) Oxygen storag 3,000 cu.ft. are en separation. (b) Locations for sthan 3,000 cu.ft. a NFPA 99 4.3.1.1.2 Based on obserinterview, the fensure oxygen sprinklered oxywas properly secombustibles. Standards for Facilities, and N8–3.1.11.2(c) minimal separation and combustible building be 5 fecabinet of nonconstruction has fire protection hour for cylindapproved flamming cabinet shall be used for cylindadeficient practice. | e locations of greater than closed by a one-hour upply systems of greater re vented to the outside. , 19.3.2.4 vation and acility failed to stored in 1 of 1 vgen storage areas eparated from NFPA 99, Health dealth Care NFPA 99, requires the ations from oxygen les in a sprinklered eet or an enclosed combustible aving a minimum rating of one half er storage. An mable liquid storage epermitted to be er storage. This ce affects staff, residents on the | K | 0076 | CORRECTIVE ACTIONAII combustible plastic, paper ar cardboard wrapped supplies been removed from the oxyg storage room. IDENTIFY OT RESIDENTSAII residents affiwere identified in the finding. other residents would be impacted. MEASURES/SYSTEMIC CHANGESThe Plant Operation Director will be in-serviced regarding the oxygen storage requirements to ensure proposeparation from combustibles Staff from all departments with be in-serviced regarding the requirements to keep all combustible items out of the oxygen storage area. An auch be completed weekly of the oxygen storage room to ensuthat the space meets requirements of no combustion in the space. MONITORING CORRECTIVE ACTIONThe weekly audit results will be reported to the QA committee three months. If any negative trends are noted in the audit results, the QA committee with the complete weekly are noted in the audit results, the QA committee with the complete weekly are noted in the audit results, the QA committee with the complete weekly and the complete weekly are noted in the audit results, the QA committee with the complete weekly and the complete weekly are noted in the audit results, the QA committee with the complete weekly and the complete weekly are noted in the audit results, the QA committee with the complete weekly and the complete weekly are noted in the audit results, the QA committee with the complete weekly and the | have en HER ected No ions er s. II | 06/15/2011 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155775 | | (X2) MULTIPLE CO A. BUILDING | 01 | (X3) DATE SURVEY COMPLETED 05/16/2011 | | |
|--|---|--|---|---|----------------------|--|
| | PROVIDER OR SUPPLIER | | B. WING COST 10/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN47906 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE | |
| K0143 SS=E | Based on obser maintenance di at 12:40 p.m., storage room wastorage of plassicardboard wrap located immediliquid oxygen of the room. The director said at observation, he the separation 3.1–19(b) Transferring of oxy (a) separated from wherein patients a treated by a separ 1-hour fire-resistive (b) in an area that sprinklered, and he flooring; and (c) in an area post transferring is occur | vation with the rector on 05/16/11 the oxygen supply was used for the tic, paper and oped supplies lately adjacent to containers stored in maintenance the time of a was unaware of requirement. If any portion of a facility re housed, examined, or ation of a fire barrier of the construction; is mechanically ventilated, as ceramic or concrete that urring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 | K0143 | recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions. | age 06/15/2011 | |
| | interview, the face of 1 of | acility failed to | 10173 | has been ordered and will be installed for the oxygen room clearly indicates it is oxygen | | |

| li ´ | | (X2) M | | | | RVEY | | |
|-----------|---|------------------------------|--------|---------------------|---|------------------------|------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 01 | COMPLETI | | |
| | | 155775 | B. WIN | | | 05/16/201 ⁻ | 1 | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | | |
| OUMBEE | N AND DOINTE LIE | ALTIL CAMPLIC | | 1051 CUMBERLAND AVE | | | | |
| CUMBER | RLAND POINTE HE | ALTH CAMPUS | | WEST | LAFAYETTE, IN47906 | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T | COMPLETION | | |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | <u> </u> | DATE | |
| | sites was posted with a sign | | | | storage and will allow staff to that oxygen transfilling is tak | | | |
| | indicating oxyg | gen transferring was | | | place. The door to the oxyge | - | | |
| | taking place, p | rovided with | | | room is being replaced with a | | | |
| | continuous me | chanical ventilation | | | door that will be clearly label | ed to | | |
| | to the outside | and separated from | | | meet the fire rating | | | |
| | any portion of | the facility wherein | | | requirements. The oxygen ro is currently mechanically ven | | | |
| | | oused by a fire | | | to the outside for continuous | ieu | | |
| | | ur fire resistive | | | mechanical ventilation. IDEN | TIFY | | |
| | construction. | | | | OTHER RESIDENTSAII resi | | | |
| | | | | | affected were identified in the | | | |
| | practice affects staff, visitors and 77 residents on the Pine unit. | | | | finding. No other residents w be | ould | | |
| | 77 Testuents of | it the rine unit. | | | impacted.MEASURES/SYST | -ы І | | |
| | | | | | C CHANGESNursing staff w | | | |
| | Findings includ | ie: | | | in-serviced on the importanc | | | |
| | | | | | properly using the signage o | | | |
| | | rvation with the | | | oxygen door to indicate when | ו ו | | |
| | | irector on 05/16/11 | | | transfilling is taking place. Random audits will be condu | cted | | |
| | at 12:40 p.m., | seven liquid oxygen | | | monthly by nursing manager | | | |
| | supply contain | ers and nine small | | | ensure staff are properly usir | | | |
| | oxygen cylinde | ers were stored in a | | | signage when transfilling. A | | | |
| | room on the Pi | nes unit. LPN #1 | | | monthly preventative maintenance check will be | | | |
| | interviewed at | the time of | | | conducted to ensure that the | door | | |
| | observation sa | id the room was | | | to the oxygen storage | | | |
| | used for the tra | ansfilling of | | | room continues to have the | | | |
| | | n tanks. There was | | | proper rating noted on the do | | | |
| | | itify the room, it's | | | MONITORING CORRECTIV | | | |
| | _ | to provide notice it | | | ACTIONThe monthly audit re will be reported to the QA | suits | | |
| | | xygen transfer. | | | committee for three months. | lf | | |
| | | , • | | | any negative trends are note | | | |
| | | ire rating on the | | | the audit results, the QA | | | |
| | | ked at the time of | | | committee will recommend | and | | |
| | | ne maintenance | | | changes in the interventions extend the monthly review ar | | | |
| | | e did not know if | | | additional three months to er | | | |
| | the mechanica | | | | effectiveness of the new | | | |
| | provided exhau | usted directly to the | | | interventions. | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV OT COMPLETED COMPLETED | | | | | |
|--|---------------------|--|--------------------------|---------------|--|---------|--------------------|
| AND PLAIN | OF CORRECTION | 155775 | A. BUILDING — 05/16/2011 | | | | |
| | | 100770 | B. WIN | | A DDDEGG CITY CTATE ZIR CODE | 00/10/2 | 011 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE UMBERLAND AVE | | |
| CUMBER | RLAND POINTE HEA | ALTH CAMPUS | | | LAFAYETTE, IN47906 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE |
| IAU | | LSC IDENTIFTING INFORMATION) | + | IAG | , | | DATE |
| | outside. | | | | | | |
| | 3.1-19(b) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| K0144 SS=C | | spected weekly and lad for 30 minutes per lace with NFPA 99. | | | | | |
| | Based on obser | vation, record | K |)144 | CORRECTIVE ACTIONA que | ote | 06/15/2011 |
| | | rview; the facility | | | has been obtained and a | 0 | |
| | failed to ensure | e 1 of 1 emergency | | | remote manual stop station is being installed on the genera | | |
| | generators was | equipped with a | | | for emergency shut-off. | | |
| | remote manual | stop. LSC 7.9.2.3 | | | IDENTIFY OTHER | 4 | |
| | requires emerg | ency generators | | | RESIDENTSAll residents afformation were identified in the finding. | | |
| | providing powe | er to emergency | | | other residents would be | | |
| | lighting system | s shall be installed, | | | impacted. | | |
| | tested and main | | | | MEASURES/SYSTEMIC CHANGESThe proper function | onina | |
| | accordance witl | | | | of the remote manual stop st | _ | |
| | Standard for En | - · | | | on the generator will be chec | ked | |
| | | Systems. NFPA | | | monthly during generator testing. MONITORING | | |
| | 110, 1999 editi | | | | CORRECTIVE ACTIONThe | | |
| | • | I installations shall | | | monthly testing results will be | | |
| | | manual stop station | | | reported to the QA committee three months. If during any | e tor | |
| | • • | r to a break-glass | | | testing of the remote manual | stop | |
| | | elsewhere on the | | | station there are problems | | |
| | | e the prime mover | | | identified with functioning, the generator maintenance contr | | |
| | | de the building. | | | company will be contacted | aui | |
| | NFPA 37, Stand | l Use of Stationary | | | immediately for repair to ens | ure | |
| | | • | | | proper functioning. | | |
| | Combustion En | | | | | | |
| | 1 41 1111165, 1996 | Edition, at 8–2.2(c) | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZCO621 Facility ID:

000547 If continuation sheet Page 21 of 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155775 | | A. BUIL | LDING | NSTRUCTION 01 | (X3) DATE COMPL | ETED | |
|---|--|---|---------|---------------------|---|----------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WING | STREET A | DDRESS, CITY, STATE, ZIP CODE JMBERLAND AVE AFAYETTE, IN47906 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | the engine at the a remote location practice could at a seed on intervereview on 05/1 with the maintenance did the time of recording the time of recording the time of the emergency shut emergency shut emergency generator of the found. A call progenerator contract 2:10 p.m. by | more have ne shutting down ne engine and from on. This deficient affect all occupants. e: view during record 6/11 at 11:20 a.m. enance director, the regency generator fter 2003. The irector also said at ord review, he here was a remote t off for the herator. Upon ne generator and s on 05/16/11 at emote emergency generator was placed to the ractor on 05/16/11 v the maintenance med no such device | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155775 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING (70) (70) (70) (70) (70) (70) (70) (70) | | | ETED | | |
|---|--|--|----|--------------------------------|---|-------|------------|
| NAME OF P | ROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP CODE UMBERLAND AVE | | |
| CUMBER | RLAND POINTE HE | ALTH CAMPUS | | | LAFAYETTE, IN47906 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID PROVIDER'S PLAN OF CORRECT. | | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE. | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| K0147 SS=E | Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 | | | | | | |
| | Based on obse | rvation and | K(|)147 | CORRECTIVE ACTION1. A | | 06/15/2011 |
| | interview, the f | acility failed to | | | receptacle is being installed | | |
| | | cords were not | | | comprehensive care unit for aquarium to be plugged into | | |
| | used as a subs | | | | Extension cords have been | | |
| | wiring in 2 of 8 | 3 smoke | | | removed from the activities | | |
| | _ | NFPA 70 (National | | | room. 3. Extension cords have been removed from room 221 and the bed has been plugged | | |
| | - |), 1999 Edition, | | | | | |
| | Article 400-8 requires, unless | | | into the wall receptacle | - | | |
| | specifically permitted, flexible | | | | properly. IDENTIFY OTHER | | |
| | | es shall not be used | | | RESIDENTSAll residents af | | |
| | | for fixed wiring of | | | were identified in the finding other residents would be | . NO | |
| | | nis deficient practice | | | impacted.MEASURES/SYS | TEMI | |
| | | aff, visitors and 52 | | | C CHANGESStaff in all | | |
| | | e comprehensive | | | departments will be in-service | | |
| | unit and 200 h | • | | | regarding the requirements extension cords and that fle | | |
| | compartment. | an smoke | | | cords cannot be used as a | | |
| | compartment. | | | | substitute for fixed wiring. A | | |
| | Findings includ | le: | | | audit will be completed mon | - | |
| | Tillulings illelue | ie. | | | inspect resident rooms, office and common areas to ensure | | |
| | Pacad on obse | rvation with the | | | items are plugged into | _ | |
| | | | | | receptacles | | |
| | | irector on 05/16/11 | | | appropriately. MONITORING | | |
| | between 10:15 | | | | CORRECTIVE ACTIONThe monthly audit results will be | | |
| | · · | ving was observed: | | | reported to the QA committee | e for | |
| | - | rip extension cord | | | three months. If any negativ | | |
| | _ · | r to an aquarium in | | | trends are noted in the audit | | |
| | | oss from the | | | results, the QA committee w | rill | |
| | • | unit nurse station; | | | recommend changes in the interventions and extend the | | |
| | <u>-</u> ' | ip extension cord | | | monthly review an additiona | | |
| | was piggy backed to an extension | | | | three months to ensure | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155775 | | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | (X3) DATE S COMPL 05/16/2 | ETED | | |
|--|---|---|---|---|------|----------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN47906 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| | 3. Two extens use on the resi room to power chair in room 2. The maintenanthe time of obsunaware of res | activities room; ion cords were in dent bed side of the lighting and a lift 221. ce director said at servations, he was trictions for the use and extension | | effectiveness of the new interventions. | | | |